# Community as the Doctor

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As the study of man yields a greater understanding of the social factors that motivate him, channel his activities, sicken or gratify him, it is not surprising that increasing attempts are made to put this information to work in constructing whole social systems designed to realize specific human goals.[1]

Romantics and Utopians among philosophers, theologians, political reformers, and even anthropologists themselves have frequently in the past visualized social systems that seemed to them ideal in some sense. These movements have always been of interest to social science, at least as data. The contemporary social psychiatric movement involving the idea of "therapeutic communities" has a special kind of additional interest. Like some of the romantics, it has nostalgic elements, harking back after aspects of earlier familistic kinds of social organization and seeing in the folk-like, *gemeinschaftlich* kind of system many features valuable for mental health. Like some religious or political reform movements, it has based much of its program on what William James referred to as a struggling away from evil as much as on a struggling toward a clearly defined "good," and it sets its program forth with conviction and moral fervor that are not lightly put aside.

The social psychiatric trend supporting the therapeutic community idea turns around Lawrence K. Frank's early injunction that society as well as disorganized individuals should receive psychiatric attention,[2] and proposes that society as well as trained individual specialists have potentialities for treating casualties of social processes. The construction of small societies of the therapeutic community type is advocated as a means through which this goal can be achieved.

The aim of this paper is to examine some of the ways in which a leading proponent of the therapeutic community approach has set about the job of constructing such a social system, and to offer some critical observations about the functioning of the system from a social anthropological point of view. In addition to the implications for therapeutic practice, some possible implications for more general anthropological study will be indicated.

## The Hospital

The hospital we have observed is the Belmont Social Rehabilitation Unit in England (Maxwell Jones, Director).[3] This Unit is part of a larger neurosis center serving all of the United Kingdom under the National Health Service. It is an open, voluntary hospital, admitting as far as its referral channels can effectively screen them, patients who are not suffering from acute psychotic disturbance, yet whose difficulties in social adjustment seem of a psychological kind. The Unit favors patients with long-standing personality disorders of the acting-out type (so-called "psychopathic personalities" or "character disorders"). It treats, at any given time, 100 patients, about 1/3 female and 2/3 male. The average time of treatment is 4-6 months, though some patients stay up to a year, and others leave very shortly after admission (approximately 20% in the first month). The staff are set up according to a relatively standard health service organizational table, with a psychiatrist in charge, three other doctors with psychiatric training assigned to the Unit, and a complement of nurses, a social worker, psychologist, and so on. The numbers of staff are somewhat larger than usual for the health service, because of the experimental nature of the Unit, but its principal differences from other similarly designated organizations is in reference to the Unit's treatment ideas. Once assigned to the Unit, staff members and patients are all expected, according to Unit "culture" (as they themselves refer to it), to give up their preconceptions about the roles of patients and medical staff, and to relate to one another as individuals with certain kinds of problems to solve. The problems are defined in terms of individuals' difficulties in adjusting to the regime of Unit life, which is set up in as simple a basic form as they consider possible. The difficulties of adjustment in the Unit are assumed to reflect the individual's characteristic difficulties in comparable situations on the outside. The ways in which individuals are expected to join together, both in forming this regime and in working on the problems created by its members' malparticipation, are encompassed in what we refer to as the Unit's *treatment ideology*.

## Treatment Ideology

The Unit's treatment ideology implies a blueprint for a social structure. That part of the social structure that consists of the Unit members' role definitions and their round of organized activities is based on the staff's particular ideas about the nature of disorder and the best kind of social system in which diagnostic processes can be engendered.[4] In our early study of those ideas and values, we grouped them into four major themes:[5]

a) *Rehabilitation:* according to which the group goal is set of restoring individual patients to an ordinary social role outside the hospital (rather than segregating them for their own or others' putative benefit); the attitude is taken that this is possible and that it can be achieved by active rational

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1. This paper stems from work at the Belmont S.R.U. (Maxwell Jones, Director), sponsored by the Nuffield Foundation. An early draft was read at the American Anthropological Association meetings in Chicago, December, 1957.

2. Lawrence K. Frank, *Society as the Patient; Essays on Culture and Personality,* Rutgers University Press, 1950.

3. Maxwell Jones, *et al., The Therapeutic Community,* Basic Books, New York, 1953.

4. M. Jones and R. Rapoport, "Social and Administrative Psychiatry," *The Lancet,* 2:386 (1955).

5. R. Rapoport, "Oscillations and Sociotherapy," *Human Relations,* IX (3), (1956).

efforts by individuals relating to one another in prescribed ways. Other aspects of this theme are the emphasis placed on active hospital-community relationships (employers, family members, etc.); and the emphasis placed on continual confrontation of the patients with "reality" in the form of at least indicating ordinary social perceptions of their conduct, ordinary norms and sanctions (rather than "humoring" them).

b) *Permissiveness:* according to which all members of the group are enjoined to tolerate from one another a wide degree of behavior that might be distressing to them or seem deviant according to "ordinary" norms. Ideally this should allow both for the individual stimulating a reaction to make his difficulties known through being allowed to demonstrate them (rather than being forced to suppress them), and for the individual reacting to examine the basis for his own sensitivity. Permissiveness is viewed as essential in developing a sense of trust (considered a prerequisite of psychotherapy) in the face of patients' tendencies to "test out" the authorities' malevolence by provocatively deviating from their expectations. It is also considered valuable for facilitating role rehearsals. In ordinary life, sanctions exerted when patients of this type contravene social norms tend to prevent them from effectively modifying their behavior patterns even given their wish to change. A sheltered, permissive environment is considered valuable in allowing for the inevitable mistakes in trying out new patterns.[6]

c) *Democratization:* according to which each member of the community is urged to exercise equal power in decision-making about all the community's affairs, therapeutic and administrative. This is considered valuable in encouraging individuals to take on real responsibilities aimed at enhancing their sense of self-esteem. An underlying element in this theme is the idea that everyone can contribute to the therapeutic enterprise, and that the contributions may be of similar kinds, and that the effective ones may come from any quarter. Thus, there tends to be a blurring of role differences, with legitimation given to all types of staff and patients to make interpretations, give advice, help in practical ways, e.g., with nursing care, serving as exemplars, and so on.

d) *Communalism:* according to which sharing, informality, and the "freeing of communications" are prescribed. The total knowledge ideal is considered desirable from several viewpoints; it supplements the other sharing and informality elements in giving patients a feeling of being included, "belonging" to the system, rather than being marginal, as many had been prior to treatment. Furthermore, it assures the staff of access to informal materials "fed back" to the total community so that decisions and judgments can be made on the basis of the consensus of as large a group as possible.

## Critique

Our study of the Unit indicated several important points about the functioning of the system with reference to these ideological themes:

a) The explicit aspects of the themes clearly derive from reactions *away from* undesired elements of the old custodial mental hospital system. However, as they tend to be stated ("free communications," "everyone has an equal say," "share everything") they seem to imply a positive value for a polar opposite state to the negatively valued conditions of blocked communications, rigid hierarchies, segregation, and the like. But polar opposite states to the ones in the old system that the staff seek to abolish, are impossible of realization.

b) Each slogan used in the Unit constitutes an explicit expression of at least one of the themes. However, the Unit staff have important implicit qualifications, discovered through observation, of which it is essential to be aware, if one is to understand the themes as they actually, rather than ideally, function in the Unit.[7] Thus, while the staff urge the "freeing of communications," observations indicate that they in fact favor verbal over non-verbal communications (though the latter may be tolerated and even encouraged at certain stages of treatment and under certain conditions); communications in groups are favored over communications between individuals in private; communications in groups containing staff members, or at least "constructive" patients, are favored over communications in clandestine, hostile, or unsupervised groups; furthermore, communications are seen to involve receptivity to others' communications, and judgments about the appropriateness of one's own in particular group contexts.

c) Actual limiting factors, aside from implicit and explicit qualifications that curtail realization of each idealized condition include such things as crosscutting directives from other ideals (e.g., if being permissive in a given situation is being at the same time unrealistic); crosscutting medical prescriptions (e.g., if being realistic in a given situation in terms of the norms for behavior outside the hospital would be detrimental to the person's health at any given time); pressures from the external relations of the Unit (e.g., if the hospital superintendent insisted that certain action be taken with regard to a troublesome patient, regardless of group consensus within the Unit, the troublesome patient would have to be disposed of as directed); personal anxieties of individual staff or patients; the overall state of organization of the system as a whole, and so on. These factors fluctuate in saliency, and they function with variable force in any given situation to determine the course of events.[8]

d) From the therapeutic point of view there is a diversity of response to the treatment method. Some patients seem to get better, some get worse. It seems clear that differences in personality or illness type are not the exclusive determinants of these differences of reaction. Another major determinant is the variability in the overall functioning of the Unit. Still another would seem to stem from the characteristics of the

6. S. Parker, "Role Theory and the Treatment of Anti-Social Acting-Out Disorders," *British Journal of Delinquency,* VII (4), (1957). Also Robert Rapoport and Eileen Skellern, "Therapeutic Functions of Administrative Disturbance."

7. M. Jones and Robert Rapoport, "The Absorption of New Doctors into a Therapeutic Community" in M. Greenblatt, D. Levinson, and R. Williams (eds.), *The Mental Hospital and Patient Care,* The Free Press, Glencoe, Ill., 1957.

8. Rapoport, *op. cit.* Also, Robert Rapoport and Rhona Rapoport, "Democratization and Authority in a Therapeutic Community," *Behavioral Science,* II (2), (1957). Robert Rapoport and Rhona Rapoport, "Permissiveness and Treatment in a Therapeutic Community," *Psychiatry* (in press). S. Parker, "Disorganization on a Psychiatric Ward: The Natural History of a Crisis," *Psychiatry* (in press).

family and other significant relationships of the patient external to the Unit.[9] Given this situation, the issue seems to revolve around the question of how to *individualize* treatment to meet the therapeutic requirements of each case, while at the same time maintaining as many as possible of the advantages of the communal-permissive-democratic regime.

## Discussion

Several points can be abstracted for discussion as relevant both to the construction of therapeutic communities and to theory in the field of structure-culture-personality study.

1) In its most general form the question can be put as to whether the treatment method should be standardized for all patients once admitted to the Unit or differentiated according to particular patients' needs: The Unit's assumption is that one social structure and one ideology can produce uniform treatment results while differentiation of treatment method by individual patient may lead to harmful effects by contravening the principles of equalitarianism and communalism.

This view seems based on the assumption that *neither* the custodial way of forming institutional communities nor the private psychotherapeutic method on the other extreme is optimally effective for providing re-socialization experiences for large numbers of psychiatric patients, the former being too suppressive and remote from ordinary life, the latter requiring too specialized a type of patient. However, their assumption that a new form of institutional experience will be suitable for a variety of types of patients seems to have new problem areas. Even a careful screening of intake for the single diagnostic category of "personality disorder" does not adequately assure uniformity even in *direction* of response. If one assumes that uniformity of response in the direction of mental well-being is desirable, it would seem that more attention should be given to how treatment experiences can be individualized within the context of a therapeutic community.

The points that follow exemplify some more specific features of Unit structure or culture that might be discussed in terms of making further progress in this direction.

2) The question of the degree of structural role differentiation that is therapeutic: The Unit's view is that formal bases for role differentiation should be blurred as much as possible, so that individual differences can determine participation patterns. This view seems to be based on the assumption that role differentiation necessarily is accompanied by rigidity in the system and that it promotes impersonalization of relationships and routinization of participation. These characteristics are seen by the Unit as anti-therapeutic aspects of the conventional mental hospital system.

A contrasting view in contemporary administrative psychiatry is that clarity of role differentiation is essential in any organization for maximizing efficient use of resources and for promoting patients' orientation in the treatment situation.

Blurring does not necessarily entail flexibility, and clarity does not necessarily entail rigidity; it would thus seem that future developments might profitably concentrate on social role definitions that allow flexible interchanges of function without sacrificing clarity of role definition and of the boundaries and limits within which the system is operating.

Thus, if impersonal experiences are regarded as detrimental for patients, the structure may provide for *personal* experiences while clearly defining the types and limits of relationship possibilities. The probability that different patients will need different types of relationships at different periods of their treatment only further underlines the need for clarifying rather than evading the question of role definition, but within a framework of broad limits and flexible functions.

3) The question of the location and distribution of authority and responsibility: The Unit's view is that status hierarchies should be leveled and authority and responsibility distributed equally among staff and patients. Their assumption is that hierarchical organization stimulates negative reaction from patients and restricts spontaneity of their self-expression and interpersonal communications.

A contrasting view is that authority and responsibility should be located in the hands of those who are most highly skilled and trained in the appropriate fields. Aside from the skill factor, the point is made that the clear and explicit location of authority is essential for treating psychiatric patients. According to this view, ambiguities, arbitrary shifts, denial and abdication of authority by those who formally hold it may in themselves be harmful to patients.

The Unit's view seems to have derived from a situation in the conventional mental hospital system where those in authority used their power in a rather arbitrary and coercive way and where skills for dealing with dynamic intra- and inter-personal situations were not well developed in the professional status groups. However, the exercise of authority and acceptance of responsibility for authoritative action need not be confused with authoritarianism; nor can it be assumed that "democratization" can *ipso facto* deal effectively with problems of administering a hospital and of treating complex psychopathological states. While mental hospital systems in which only a few top echelon people have anything to do with decision-making seem to be characterized by poor personnel relationships and patient responses, it does not follow that the total dispersal of authoritative functions will yield high staff morale and patient improvement. It would seem that the location of authority and responsibility should be clear, though the participation in opinion formation and decision-making may be broadened to include the patients and those personnel closely associated with them.

4) The question of organizing treatment ideologies into a constant versus a varying hierarchy of values: The Unit's view is that its ideological tenets are valuable in a general way for the organization of a psychiatric institution, without any necessity for predetermining any kind of hierarchy among them. The principles are to be applied in any given situation according to the consensus of the participating group. This view seems to be based on the assumption that arranging a set of principles or regulations in a predetermined hierarchical way is characteristic of bureaucratic and suppressive social systems and infringes on the tenets of permissiveness and spontaneity.

Study indicates that the lack of a clear set of principles for determining which treatment value shall have ascendancy

9. Rhona Rapoport and Irving Rosow, "An Approach to Family Relationships and Role Performance," *Human Relations,* X (3), (1957).

over others at points of intersection leads to recurring dilemmas. These dilemmas tend to be resolved according to a variety of kinds of expedients by individuals meeting them. It seems clear that at some points one treatment value (e.g., "permissiveness") is more therapeutic for a patient than another similarly endorsed treatment value (e.g., "reality confrontation"); while at another time or for another patient the reverse ranking of the two values might be appropriate. The problem is one of how to resolve dilemmas in a systematic and therapeutically responsible way. It would seem that future developments in the study and formulation of treatment ideologies should concentrate on the principles for articulating the values as well as on the actual definition of the values themselves.[10]

5) The question of whether a Unit of this kind should be autonomous and removed from close interaction with a larger institution or kept a part of a larger conventional hospital: The Unit's view is that being attached to a larger hospital serves several valuable functions. It keeps the Unit within the context of ordinary medical practice as against the potential drift toward deviancy and attendant marginality that autonomy might bring, given the Unit's peculiar principles of organization. Furthermore, the Unit's position of semi-autonomy within the larger structure assures that much of the routine administration (feeding, buildings maintenance, finance) will be taken care of by a bureaucratic system *external* to the Unit itself, keeping these functions and their attendant type of interpersonal orientation largely out of the treatment situation. Authoritative acts necessary for administering any institution can, in this context, be assigned to an external source, allowing the Unit staff to come closer to behaving consistently with their ideology of equalitarian communalism. From the hospital's point of view the Unit provides a place to which troublesome patients may be referred, and to the extent that its unconventionality is considered "progressive" the hospital accrues a certain amount of prestige from the association.

On the other hand, it seems clear that the Unit's position has some features that may function disadvantageously both in terms of its own therapeutic goals and in terms of the hospital's interests. The displacement of the locus of authoritative activity onto an external source of power, with the attendant connotations of fear and disapproval of such exercise of power may tend to promote attitudes that are antithetical to therapeutic goals. It is recognized by the Unit staff that rehabilitation is fostered by coming to take a more *positive* attitude to the larger authority system and to adopt within oneself the capacity to accept an appropriate sense of authority and responsibility.

Given the lack of fit between the Unit's ideology of democratization and its formal relationships with the larger organization with its hierarchies, formalized codes of ethics and responsibility, etc., it is inevitable that strains will develop in which each periodically sees the other as working at cross-purposes to its own goals.

When such a situation exists, if the populations being served are to retain positive orientations to the entire field of organizational forces, rather than functioning by opposition, it would seem that the subsystem must either come more into congruence with its host's pattern, or assume a detached autonomous position, with all the readjustments this would entail. In order for a subsystem to function within a larger system despite differences of organizational principles, the services provided one another must outbalance the inconvenience or other dysfunctions entailed in this form of organization. Any therapeutic community must consider the functions and dysfunctions of operating as a subsystem within a larger institution or as an autonomous institution on its own in the kinds of terms described above, and the solution will vary according to the component elements in each situation.

6) The question of the degree to which a therapeutic community should be a microcosm of the larger society: The Unit's view is that the hospital community should provide a "realistic" round of experiences and relationships for the patient—a miniature of his outside type of life—both for purposes of diagnosing his recurring difficulties and for working out new, rehabilitative patterns. This view was based on the feeling that the artificial and suppressive existence of custodial mental hospitals led to the capacity to live only in sheltered institutions.

On the other hand, it is clear that hospitals *cannot* reproduce identical patterns of relationships—e.g., family life—and, furthermore, study reinforces the views that too "realistic" a confrontation of some patients with others' perceptions of their behavior only exacerbates the difficulties initially stimulated in society at large. Patients, as casualties of the social processes in the world outside the hospital, may need *different* conditions in which to recover or nurture their capacity to live in psychic health. On the other hand, where the goals of the treatment institution are to *restore* rather than simply to care for society's psychiatric casualties, continuities between the world of the hospital and the world outside seem called for.

In future developments of therapeutic communities, it would seem that the apparently incompatible criteria of "realism" (i.e., resemblance to the external way of life) and special milieu requirements for therapy can be reconciled by giving careful attention to *gradations* of social experience. According to this view, patients need not be assigned to a particular type or level of social milieu according to their *date* of entry; nor according to their illness type—but according to the progress they make toward the capacity to function within a framework of outside-life activities.

The stages set up to treat the individuals' illnesses need to be diversified according to illness type; the stages set up to provide graded pathways to discharge into ordinary life need to be differentiated according to the varieties of treatment goals and subcultures into which the patients are expected to emerge from the hospital.

10. Social anthropologists have themselves made greater strides toward conceptualizing cultural elements in terms of themes or kindred concepts than they have in conceptualizing in forms of themal articulation. Benedict's "total culture pattern" offers a rudimentary conceptual basis for ranking patterns within a culture, as does the idea of "core culture" as set forth by, for example, Julian Steward. Florence Kluckhohn's "dominant and variant" patterns within the culture's profile of value orientations also may be seen as an attempt to deal with this problem. This seems to be a field of great theoretical as well as practical importance for attention in the near future.